

Touchstone

A Journal of the Hamilton Civic Hospitals

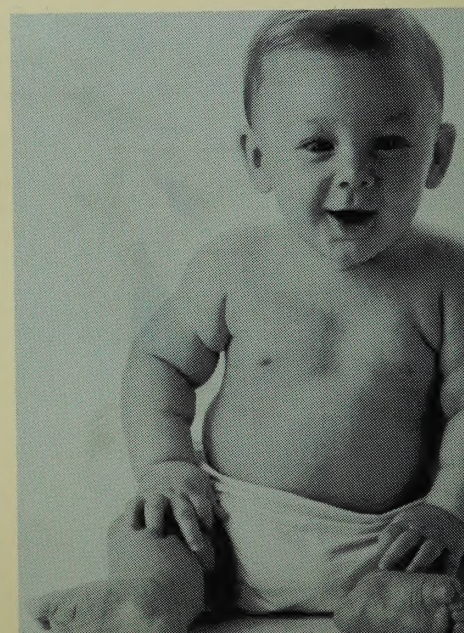
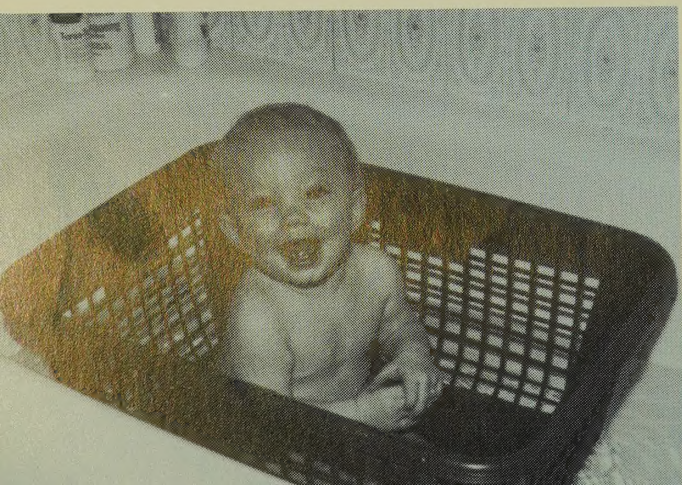
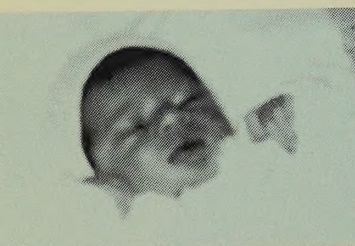
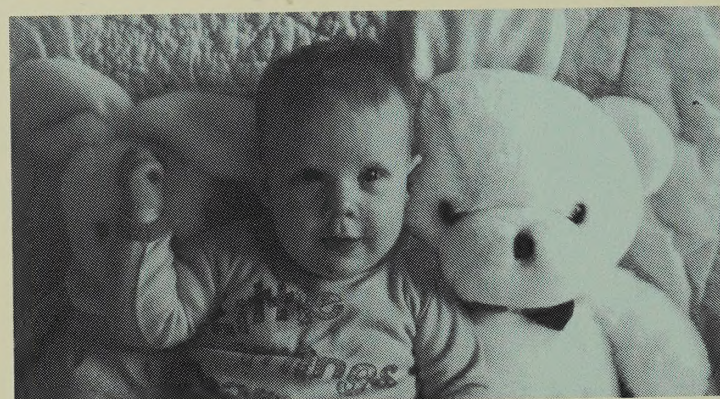
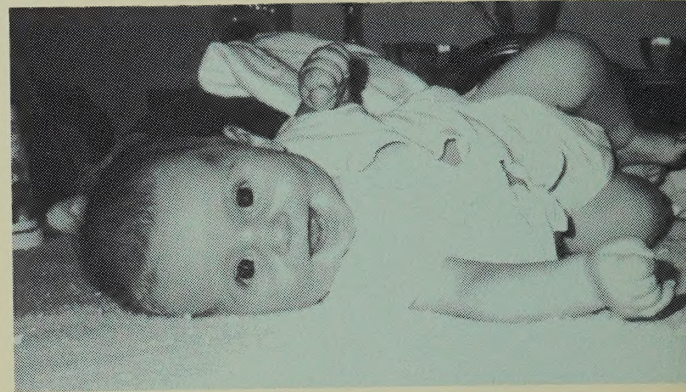
Volume 2, Issue 2

URBAN/MUNICIPAL

PA 4 ON HBL I83
754



Includes
1987/88
ANNUAL REPORT



Contents

URBAN MUNICIPAL

JUL 19 1988

Touchstone

GOVERNMENT DOCUMENTS

*A Journal of the Hamilton Civic Hospitals
Volume 2, Issue 2.*

Touchstone is published quarterly by the Public Relations Department, Hamilton Civic Hospitals, 237 Barton Street East, Hamilton Ontario, L8L 2X2

The Hamilton Civic Hospitals comprises two divisions: Henderson General and Hamilton General.

Chairman of the Board:
Mr. A.G. Northcott

President & C.E.O.
Dr. W.E. Noonan

Director, Public Relations:
Mr. P.L. Hill

Editor, Touchstone:
Ms. F. O'Flynn

Editorial Advisory Committee:
Mr. R. Swenor (Chairman),
Ms. D. Fortnum, Dr. F. Fraser,
Mr. P.L. Hill, Dr. J.M. Phin,
Dr. M. McQueen, Dr. T. Seaton,
Dr. A. Turpie, Ms. F. O'Flynn

Produced by:
Public Relations Department,
Hamilton Civic Hospitals

Design & Production:
BASE LINE Graphics

Photography & Illustration:
Audio Visual Department
Hamilton Civic Hospitals
Mrs. Kathleen Brown
YWCA (McNab Street)
BASE LINE Graphics
Mrs. Bonnie Leuser
Dr. Douglas Wilson,
McMaster University
The Canadian Cancer Society

Anyone is welcome to reproduce articles from **Touchstone**. We would appreciate credit, however.

Please contact us with suggestions, comments or additions to our mailing list at (416) 527-0271 Ext.: 4384

	Page
EDITOR'S COMMENT	2
The McGRATTAN TEAM	2
MATERNITY Then & Now	3
SURVEY RESULTS	4
FACE To FACE To FACE	5
TRANSFUSION TEAM	7
POST-PARTUM EDUCATION	8
(URO) DYNAMIC APPROACH ...	12
SCOPING	13
SEXUAL MEDICINE	14
FRIENDS Of The CIVICS	15

1987/88 ANNUAL REPORT

FACTS & FIGURES	16
HIGHLIGHTS 1987/88	17
BOARD Of DIRECTORS	18
FINANCIAL STATEMENTS	22
MEDICAL STAFF ADVISORY LIST	Inside Back Cover

A **Touchstone** is "a kind of stone used for testing the fineness of gold and silver ... hence a standard for testing quality." To us, the **Touchstone** connotes a sense of excellence, innovation and dedication, plus a feeling of warmth and caring. These five elements - symbolized by the five-sided touchstone to the right - are central to all our activities at the Civics; they are our standards and this is what we want our journal to reflect.

Frances O'Flynn
Editor



The McGrattan Team

This issue of Touchstone is multi-faceted. It celebrates the 50th Anniversary of the Maternity Unit at Henderson Division and highlights the Unit's philosophy of family-centred care. It also examines other components of the Obstetrics and Gynecology Department at Henderson to show something of the breadth of care available. And, for the first time, it includes the Hamilton Civic Hospitals Annual Report to the community. We hope you enjoy all facets of it.

Because the inclusion of the Annual Report (which until now has been a separate publication) is an experiment for us, we would be glad of some feedback from you. An upcoming issue of Touchstone will include a readers' survey and we'll ask then whether you felt it appropriate for the Spring/Summer issue of Touchstone to contain our Annual Report. However, if you'd like to let us know now, please do.

In the next issue, we'll return to normal, with News and People and Perspective columns (which we dropped this time because of the addition of the Annual Report). In the meantime, thanks for participating in our 'great experiment.'

Frances O'Flynn
Editor



Sarah Louise McGrattan, our cover baby, was born January 6--a Henderson baby of the 80s. Of course, her parents, Lorraine (who, incidentally, works for the Hamilton Civic Hospitals Foundation) and Terry, bear more than a little responsibility for bringing Sarah into this world! But they willingly share the stage with many others. On our cover, with the McGrattans, are some members of the cast who played important roles. Of necessity they are the few who represent the many--not all the players were available to be photographed. However, they help us demonstrate the teamwork that is such an important part of care throughout the Maternity Unit.

Sarah is a Henderson baby of the 80s because she was among the 1,000 plus infants born in one of six new Labor/Delivery/Recovery (LDR) rooms at Henderson. LDRs put a physical face on the Unit's family-centred care. Finally, the staff says, our facilities support our philosophy!

Inaugurated in June, 1987, LDRs are bedroom-like rooms that allow new moms to labor, deliver and recover in one place. Birthing beds in the LDRs offer more comfortable positions in which to labor, while bedroom furnishings and soft mauve and pink color schemes belie the fact that emergency equipment is at hand, stored behind a curtain. Moms are spared the discomfort of moving through three different areas (labor in one; delivery in another; recovery in a third) and they benefit from having the highly skilled labor and delivery nurses at their sides, supporting rather than transferring them from room to room.

Everything about the room is intended to relax the mother and her companion and reduce anxiety. Says Maternal and Child Health Clinician, Mrs. Valerie Adam, "We try to keep in mind that although hospitals become very

comfortable places for health care providers--because we spend so much time there--they can be very frightening to patients who are experiencing a crisis when they are admitted. Even if it is a positive, heightened experience like childbirth. We feel that LDRs combine the best of both worlds: sufficient equipment and scientifically based care to handle any emergencies plus the family centred orientation of a home-like birth."

As the one-year anniversary of LDRs approaches, Mrs. Adam and Director of the Department, Dr. Ken Lamont, have done a survey on their use and some interesting trends have emerged. As Dr. Lamont suggests, the objective of LDRs was to bring the facilities into line with the Unit's family-centred approach, "we also hoped it might decrease interventions, such as cesareans and forceps deliveries. Our mini-survey has given us reason to think this may be the case." The graphs on page 4 illustrate his point.



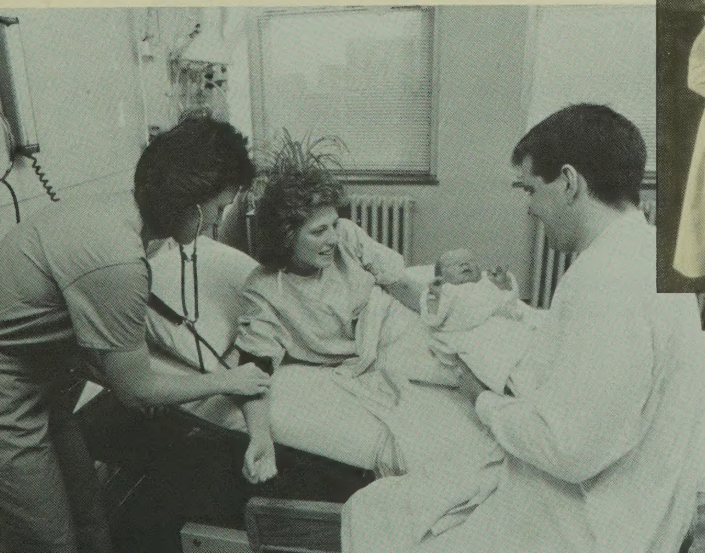
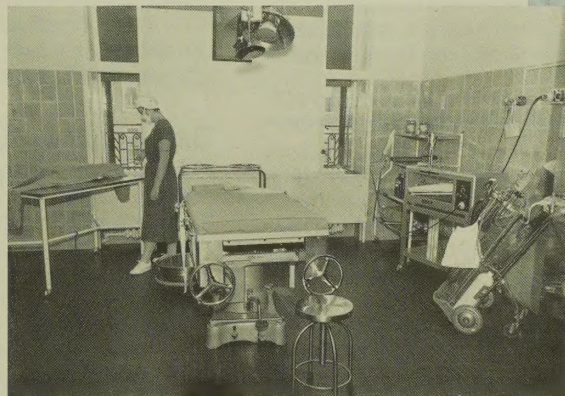
1. Sarah McGrattan, 2. Odette Sabourin (Labor & Delivery nurse), 3. Lorraine McGrattan (Mom), 4. Terry McGrattan (Dad), 5. Paul Fawcett, M.D. (Ob/gyn), 6. Linda Belovari (Labor & Delivery nurse), 7. Angela Farrelly (Labor & Delivery nurse), 8. Diane Brecht (Laboratory), 9. Alison Ward (Laboratory), 10. Marcie Sheldrake (Laboratory), 11. Barbara Lewis-Davis (Nursery nurse), 12. Jo-Ann Malcolm (Nursery nurse), 13. Donna Simpson (Neonatal ICU nurse), 14. Beate Jessel (Neonatal ICU nurse), 15. Janis Risko (Neonatal ICU nurse), 16. Trudy Cooper (Neonatal ICU nurse), 17. Ron Pye, M.D. (Pediatrician), 18. Julie Frank (Laboratory), 19. Anne-Marie Monforton, M.D. (Resident), Missing - Laura Fox (Labor & Delivery nurse).

The McGrattans had reason to be thankful for the emergency care and equipment readily available, but not disrupting the home-like atmosphere. What was to be an

uncomplicated delivery grew complicated when Sarah became entangled in the umbilical cord early in labor. The medical staff acted quickly and were able to relieve the stress. "There was trauma," says Lorraine McGrattan, "But they acted instantly, and had all the equipment necessary to handle it."

All's well that ends well...Sarah Louise McGrattan is six months old this month. She weighs 20 lbs., has four teeth, sleeps through the night and, as our photographer can testify, she's a trooper in front of the cameras. The McGrattan team has a lot to be proud of.

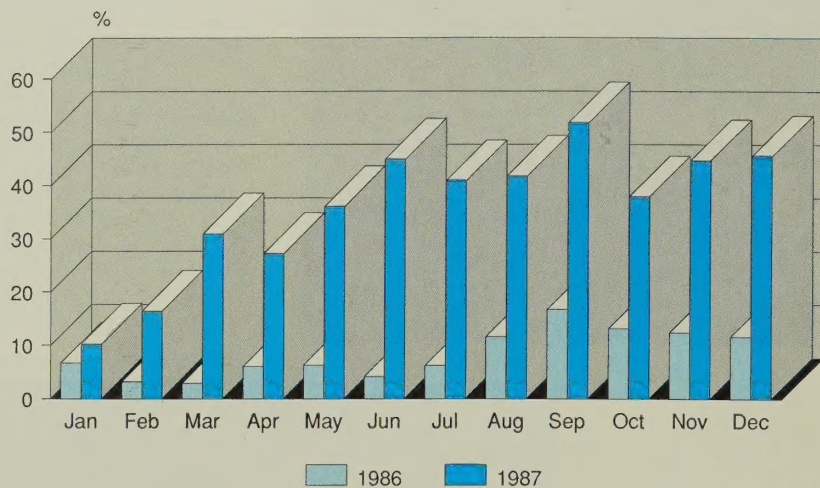
Maternity Then & Now



Survey Results

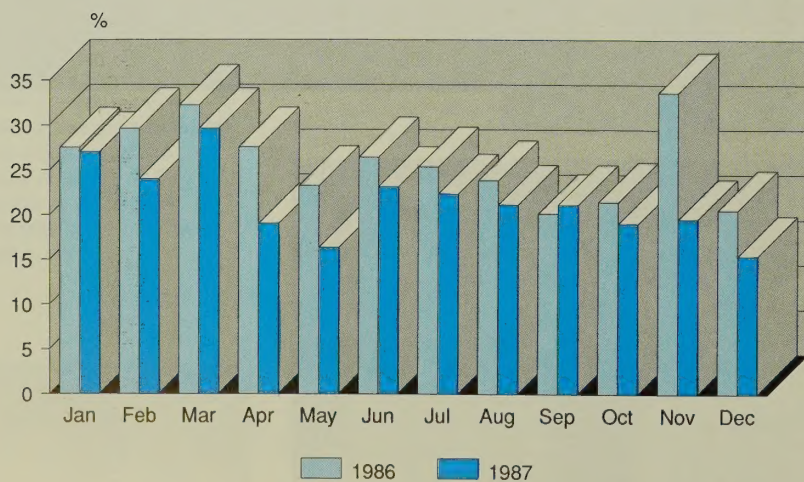
LDR Use

Between 40 and 50 percent of Henderson Maternity clients preferred to give birth in LDRs in 1987 as against a peak of 13 percent in 1986.



Cesarian Sections

The percentage of cesarean sections done at Henderson dropped 4.5 percent.



Face To Face To Face

Dr. Ken Lamont, Director of the Obstetrics and Gynecology Department and some members of the Ob/Gyn team talk to Touchstone Editor, Frances O'Flynn, about the Department's philosophy

This fall, the Hamilton Civic Hospital's Maternity Unit at Henderson Division will celebrate its 50th anniversary. It will be a milestone for staff and for the more than 100,000 babies born here over the years. It also will be our 'news focus' for this issue of Touchstone. Although not the only one...

The first issue of Touchstone (Fall, 1986) included an in-depth examination of the Maternity Unit: we looked at its past, its present and its future; and we described its philosophy of family-centred care. The Unit's strength, we suggested, grows out of two key factors: a stress on education and the team approach.

In this issue, we expand our scope to include other components of Henderson's Obstetrics and Gynecology Department. And find, not surprisingly, that the same two factors are responsible for shaping them as well.

We say 'not surprisingly' because the Director of the Ob/Gyn Department, Dr. Ken Lamont, shares a common vision with the medical and nursing staffs and other professionals who are affiliated with the Department. The vision is characterized by the following: a total approach to patient care; a commitment to preventive medicine and education; and a belief that patients should share in decisions about their own care. And while research and up-to-date technology play important roles in Ob/Gyn at Henderson, in the vision it's people who count.

In the section below Dr. Lamont and several members of the Ob/Gyn team provide some insight into this philosophy of care:

Touchstone: Dr. Lamont, what comprises the Department of Obstetrics and Gynecology at Henderson?

Dr. Lamont: At Henderson, we are considered a Level II obstetrical unit, meaning we diagnose and treat selected high-risk pregnancies as well as uncomplicated cases. The region's high-risk pregnancy program and the high-risk neo-natal units are located at Chedoke-McMaster Hospitals and both

Henderson and St. Joseph's hospitals refer patients there when necessary.

Three sub-specialists in gynecology also are based here: oncology, urodynamics and sexual medicine. As well as providing a large general gynecology service, we are the regional centre for gynecologic malignancies (a program which is associated with the Ontario Regional Cancer Centre housed at Henderson) and women throughout the Region with abnormal pap smears likely will be diagnosed and possibly treated at the colposcopy clinic located here. As well, the program of managing female urinary problems, using urodynamic assessment, is based here. And recently the sexual medicine program moved to Henderson providing a new dimension to the Department.

Touchstone: Could we talk about the role of education in the Department?

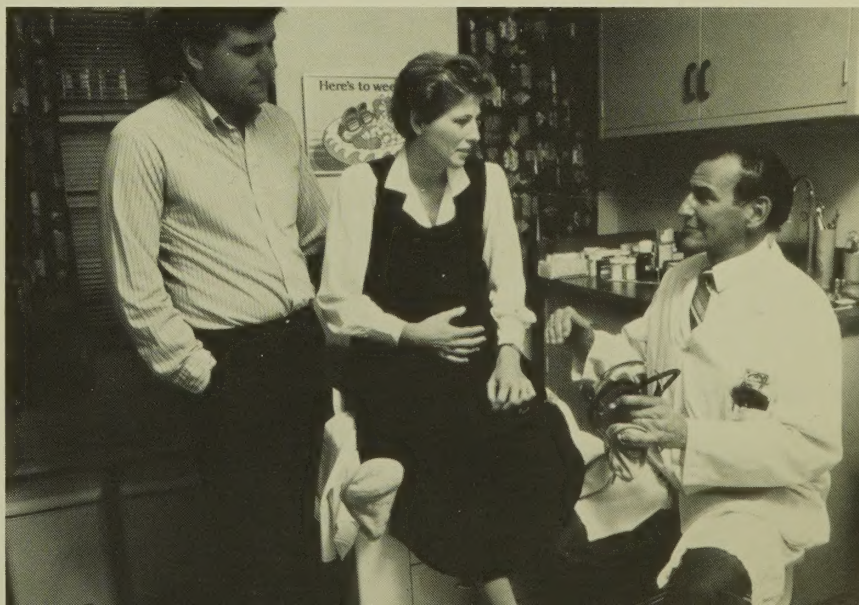
Dr. Lamont: Yes. Because education is a vital and growing responsibility within the department.

First, and of great importance, is our position as a department within a teaching hospital, with a responsibility for training future caregivers. These include medical and nursing staff as well as technologists, social workers, physiotherapists and others who will work in obstetrics/gynecology.

The commitment to training residents in obstetrics and gynecology goes back to the early 1950s when final year residents from the University of Western Ontario program trained at the Hamilton Civic Hospitals. We also trained family medicine interns and residents in obstetrics and gynecology before McMaster has a Faculty of Health Sciences and now, of course, we are closely affiliated with that Faculty. Currently, we have 12 physicians here and six residents. We also have a Fellow in oncology plus a Clinical Scholar working in urodynamics.

Touchstone: What is the benefit to patients of this commitment?

Dr. Ken Lamont (right) explains the Unit's family-centred approach to expectant parents.



Post-Partum Education

Five years ago, Helen and Andy Torenzma had a stillborn child. It was among the most tragic, traumatic events of their lives. And despite the best of intentions on the part of hospital staff, Helen felt they lacked the resources that would have helped them to understand what she and her husband were going through.

Three months ago, the Torenzmas suffered another stillbirth. The emotional pain was the same. Only this time, the hospital staff understood. Nothing could bring back their baby. Or take away the pain. But now Helen felt the professionals around her had some knowledge to help her and Andy deal with their grief.

From the hospital's perspective, it was a case of responding to a need. Over the past five years, there had been an education explosion in the Maternity Unit to tie in with its philosophy of family-centred care. More than 20 post-partum education packages had been introduced on topics ranging from breastfeeding to rooming-in, post cesarean section exercises to maternal post-partum physical and emotional adjustments. These were made available to mothers and families in individually designed programs tailored to their specific needs. And it is this educational focus that today has helped to make Henderson the birthing centre of choice for many well-read, education-conscious moms- and dads-to-be.

At the same time special programs were being developed to meet specialized needs. These included prenatal preparation; gestational diabetes; Transcutaneous Electrical Nerve Stimulation for labor pain relief; early discharge; apnea monitoring; pregnancy and the RH factor; as well as the perinatal bereavement program which had altered the hospital's approach to parents like the Torenzmas.

In the case of the perinatal bereavement program a need had been identified through the Hamilton Civic Hospitals Satisfaction Questionnaire filled in by

patients on discharge, and through feedback from the nurses, who felt they could do more to support these patients. The request to consider implementing a program reached the desk of Mrs. Valerie Adam. At the same time, hospital Social Worker, Mrs. Joan Golding, (who had been instrumental in helping set up a community support group for bereaved parents and who had been working for a considerable period of time with them, both inside and outside the hospital) offered to arrange for several women who had gone through stillbirth or neonatal death to talk to the nursing staff. "We wanted to know what we did well and what we could do better," says Mrs. Adam. "Then we took their recommendations and built it into a program. It isn't perfect but it is better than before. And we continue to improve it based on feedback from patients and nurses."

To design the program Mrs. Adam and a multi-disciplinary project team followed a rigorous procedure used in designing other components of the education program. A literature search generated articles on the topic; a brainstorming session with the team and, in this case, bereaved parents, produced ideas; and the first draft of the program was submitted to staff nurses and others for input; ("It is vital to get input from the people who will be using the program," Mrs. Adam says. "And here everyone is willing to give their ideas and to critique it from a user's perspective.")

The resulting 31 - page program manual contains sections on Nursing Practices (offering parents the opportunity to see and hold their baby in the labor/delivery room in the case of known intrauterine death; arranging for a photograph of the baby, which the mother can have if she wishes; discussion of ceremonies such as baptisms and naming that can be performed if the parents wish) as well as a list of resources available (including an article on the stages of grief and literature on the Perinatal Bereavement Support Group--a self-help organization operating in the community). It also includes information on the Hamilton and District Funeral Association, with chapters on burial and on cremation.

The goals of the program include: to assist the bereaved couples in moving through the stages of grieving; to provide them with sufficient information to make decisions; to coordinate health care between various health care disciplines and community agencies; and, most important, to provide emotional, physical and spiritual care to bereaved couples. To the Torenzmas, this approach to care made a difference: "The nurse helped. She wrapped the baby up and showed it to me. She treated it like a baby and told me I could be alone with it as long as I wanted. The first time the nurses tried to persuade me not to see my baby, this time they offered me options and supported me in my decisions," Mrs. Torenzma says.

The bathing demonstration includes Dads and Moms.



Clinician
Mrs. Valerie
Adam, Kathleen
and Zachary
Brown, and
Ward 3 Head
Nurse, Adele
Chetec--
celebrating a
success!



The dual themes of education and support lie behind all the education programs available in the Maternity Unit. Says Mrs. Adam: "We try to give parents the knowledge and skills plus the understanding to assume more control over their situations." The examples below are only three of many illustrating her point. In one, Helen Torenzma tells her story; in another, a woman who had a breast reduction in her teens describes her subsequent success at breastfeeding (despite the odds) thanks to the breastfeeding program and some very special attention from the staff. The third looks at the education program surrounding TENS, used in childbirth to relieve pain.

Kathleen's Story

The Polaroid photo was inscribed, 'A great team effort; for a great breastfeeding success--Thanks to everyone!!' And all four people in the photograph, including baby Zachary, are smiling.

But behind the smiling faces is a story of courage and determination, patience and caring, as Mrs. Kathleen Brown--the new Mom--and Henderson nursing staff took on the odds. And won.

The situation was unusual. Mrs. Brown, pregnant with her second child, desperately wanted to breastfeed the new baby. Unfortunately, when she was a teenager, she had undergone breast reduction surgery and had been warned that it was unlikely she would be able to breastfeed as a result.

This did not seem upsetting to an 18-year-old who was constantly uncomfortable, both physically and psychologically, with her bust size. As she says: "I was out of proportion. I couldn't play tennis or horseback ride. So when the opportunity presented to do something about it, I did." She adds: "At that age I wasn't concerned about the breastfeeding part; I didn't give much thought to nurturing."

Times change. In her first pregnancy, inexperienced and accepting, she didn't even try to breastfeed. This time, she had read and researched all aspects of childbirth, including breastfeeding. She was convinced it was the right thing for her. "I was more prepared, more motivated. I thought, 'It's been 12 years since my surgery, there's no reason why I can't breastfeed now.'"

In many cases, motivation, no matter how strong, couldn't compensate for the physical fact that all the milk ducts had been severed in surgery. The chances of breastfeeding under those circumstances would be nil. However in Mrs. Brown's case, even though she understood that the nipples had been relocated and

many ducts severed, she was fortunate; some must have survived intact. "The milk came in on schedule," she said. "So I definitely had milk. It was getting it down through the system to Zach that was going to take work."

The Henderson breastfeeding education program includes brochures and instruction via four slide tape shows (on Comfortable Positions and on Potential Problems at Home). These, however, are intended to supplement the one-on-one hands-on instruction by nursing staff. Says Head Nurse, Mrs. Adele Chetec: "Whether a woman wants to breastfeed or not, we will support them in their decision. We're totally flexible. In Mrs. Brown's case, here was a woman who was well read, highly motivated, and patient. It was important to her and she really wanted to try. The nursing staff used all their expertise to help her breastfeed."

Also Mrs. Chetec and Clinician Valerie Adam, who designs education programs and sometimes gets involved in direct patient care, spent two straight days trying various techniques--including warm cloths and showers, Syntocinon nasal spray which helps open milk ducts, even beer, supplied by Mrs. Brown's husband, Grant. "We tried the baby in different positions. We tried frequent feedings," comments Mrs. Adam. "He sucked well and was quite content to do that while we tried to get her milk to let down. Gradually he began to get some."

Adds Mrs. Brown: "We had a major celebration when he started to take 15cc of milk. He still had to be supplemented but by the time I left he was taking 25cc (normal is 30 to 60cc). Everyone was so supportive. They did everything in their power to help. To me, it was a big success." Mrs. Chetec agrees: "I have seen several cases of women with breast implants or reductions. Each case is different. However, this is the best result I've ever seen." Much of the credit was due to Mrs. Brown's persistence and knowledge, Mrs. Adam and Mrs. Chetec believe. Says Mrs. Chetec: "She is what obstetrical nursing is all about. She was confident and knew what she wanted. plus she said what she wanted. That's the kind of communication we need. We can't read people's minds. We want to support whatever decision they make but we have to know what they're thinking."

Kathleen Brown agrees: "Read, become informed, take control. You're the one having the baby. Tell your nurses what you want and let them help you achieve it."

Post-Partum Education *Cont.*

Helen's Story

Helen Torenzma's story is a hard one to tell. In the same way as it is hard for caregivers who must realize that nothing they say or do can compensate for the loss of an eagerly anticipated child, it's hard for a writer to convey in words a tragedy that is beyond words.

However it's important that her story be told. To help others in similar circumstances and to help those of us who may not understand. Thank you, Helen, for sharing it with us.

"When I was admitted in 1983 for my first stillbirth, it was my first time. I didn't know what to do. I didn't know how to deal with it. I suspect the people at the hospital didn't know either, because although they gave me good medical care, no one talked to me about what was happening. I felt I was all alone.

"The nurses tried to persuade me not to see the baby and I wanted to see it badly. No one mentioned burial or talked about a naming ceremony. I had to fight to have her buried."

Unfortunately, Helen Torenzma's experience was the norm at that time. Caregivers, with the very best of intentions, felt it was best for parents of stillborn children to put the experience behind them as quickly as possible.

Tragically, for the Torenzmas that wouldn't be possible. They had stillborn twins two years ago:

"That time, the hospital seemed a bit more able to help," she says. "I still felt alone, trying to suppress my feelings, trying to be a good patient and not make a scene. But this time, although they still didn't seem to feel comfortable, the nurses would talk with me about it. I was given a brochure on various options I had. Now, the hospital was supplying me with resources where last time I had to do it all alone."

This past Easter, Helen and Andy Torenzma were faced with yet another tragic baby death. "Knowing my baby was dead was a pain that just ripped me to pieces," Mrs. Torenzma says. "If you had hopes and desires for life that have been replaced by death, you need time and support to cope."

She has suggestions that she feels could have provided her with additional support: "As a caregiver, don't wait for the patient to ask for something. Try to put yourself in her position. Consider making a special meal; give her something for pain or for sleep without making her have to ask; I didn't like to make a nuisance of myself but that didn't mean I wanted to be left alone."

However, she agrees that the whole approach to bereaved parents was much improved: "When I came in the Head Nurse, Mrs. Bell, introduced herself and said she was sorry to meet me in these circumstances. She made me feel welcome and believe that they were there for me." Henderson Social Worker Joan Golding also spent time with her, "talking about my feelings, discussing my support from the church. She already knew that I had planned to see the baby and that I had made arrangements for burial. She was wonderful."

Says Mrs. Golding: "There is a lot of denial. It is just too painful to deal with losing a much-wanted child. I try to encourage bereaved parents to acknowledge their feelings, to tell them it's O.K. to cry."

Labor was induced and when Mrs. Torenzma delivered, she was comforted by the nurse's reaction: "She showed me the baby, wrapped up in a blanket. And she treated it like a baby; she said I could be alone with it as long as I liked and if I wanted to see it again all I had to do was ask."

Out of the hospital, Helen Torenzma also had to deal with her husband's grief and that of her other children. "They're hurting, too. They want to support you but they hurt so much themselves that sometimes they can't do or say the right things." the Henderson bereavement program is aimed at both mother and father with information on how to help other children deal with the loss of an expected sibling.

"We really try hard to help as best we can," Mrs. Golding says. "The nurses have gone through training sessions and are really good at supporting bereaved parents. But we see them at the peak of their crisis and we're trying to deal with some major issues in a very short space of time. As well, because they're in a state of shock, they don't absorb what you say."

She concludes: "What we have works well within the time frame. We'd like to be able to have more time to deal with it more fully, but sometimes it just isn't possible before the mother gets home. Follow-up in the community is therefore very important." Parents of stillborn children are referred to the Public Health Bereavement team, which can provide referral and counselling. A critical time is two months after the bereavement. Unless the parents have been receiving counselling or have become members of a bereaved parents self-help group, this may prove a particularly difficult time for them. At this time you need support from church, family and friends, Helen and Andy Torenzma say. "Don't tell people who have lost a child, they can always have another. And don't say, 'You mustn't dwell on this.' Or 'You should have been over that long before now.' Everyone grieves in their own way and at their own pace."

Now, the hospital was supplying me with resources where last time I had to do it all alone.

At Henderson, where the grieving process has its tragic beginnings, the staff is trying to understand. And their efforts may be having some impact. Says Valerie Adam: "Until recently many of our bereaved parents left hospital within 48 hours. Now the majority are staying longer. We like to think it's because we're helping them and they're finding something they need here." As far as Helen and Andy Torenzma are concerned, the support and the resources are much improved over those of the past. And with feedback from people like them, the bereavement program will continue to improve.

'Runners high' takes on childbirth pain

Question: What does 'runners high' have in common with a new approach to managing pain during childbirth?

Answer: Endorphins generate the 'ecstasy' that may affect some runners who constantly push forward their thresholds of endurance. And as the body's natural pain relievers, they can be produced artificially to help block pain from athletic injuries. Now those properties are being put to use to provide women in labor with a means of controlling the pain of childbirth.

The approach in questions is TENS, Transcutaneous Electrical Nerve Stimulation. It relieves pain by giving off small electrical impulses that travel through the skin to interfere with pain messages to the brain and to stimulate the release of endorphins. Also used for headache and post-operative pain, TENS has really come into its own when used to take the edge off labor pain, sometimes as an alternative to medication.

The dimensions of a paging unit, with electrodes the size of playing cards, TENS can be worn comfortably on a belt or carried in a pocket. The electrodes are attached with adhesive at certain spots on either side of the spine and the intensity can be adjusted.

Does it work? One interesting study involved 51 women who were expected to undergo uncomplicated deliveries. All were given TENS units and were asked to turn off the unit during two successive labor contractions to compare the pain with or without the unit. The result: 70 percent found it useful enough to want to use it in subsequent deliveries.

The use of TENS in Henderson Maternity has grown rapidly in the 11 months since it was introduced; 25 women, in consultation with their doctors, opted to use TENS for pain relief during that period. "TENS does have a significant pain relief effect," comments Ms. Elaine Principi, the physiotherapist who instructs mothers and their partners in the use of



TENS. "but the moms also like it because it gives them control over their pain."

Literature also has indicated that the unit is more effective if couples practice with it. So after an education session that takes place a week or two before the baby is due, most couples take the unit home to practice adjusting the intensity and applying the electrodes. Currently, expectant parents rent a unit (for approximately \$30 for two weeks) from a medical equipment supply company. When parents arrive at the hospital for delivery, they will set up the unit themselves, having learned how during the education session.

Most first time users of TENS have a number of questions: Will it hurt the baby? (Studies indicate the baby is unaffected by TENS: "Uterine activity, course and duration of labor and fetal heart patterns did not differ between the [TENS and control] groups. Fetal and neonatal evaluation ... failed to reveal any differences between TENS and control infants.")* Can a fetal monitor be used? (TENS can interfere with monitoring but this can be easily solved by turning the unit off briefly and obtaining a clean trace.) Will it eliminate pain? (The answer to this is 'no' but TENS does take the edge off the pain and it may reduce or even eliminate the need for medications such as epidurals. Says Ms. Principi: "We certainly don't discourage the use of analgesics and anesthetics but for some TENS is an excellent alternative.") Will my doctor agree? (The hospital does require the physician to refer patients, who are asked to attend TENS education sessions.)

The bottom line: TENS represents a well-proven method of relieving some of the pain experienced during labor. As one anesthetist puts it, "If something minimizes the pain without any adverse effects to the mother or the baby, it's what we all want."

*Bundsen, P., Erickson, K., Peterson, L.E., and Thiringer, K. (1982) Pain relief in labor by transcutaneous electrical nerve stimulation: Testing of a modified stimulation technique and evaluation of the neurological and biochemical condition of the newborn infant. *Acta Obstet. Gynecol. Scand.* 61: 129-136.

Physio-
therapist Ms.
Elaine Principi
with Mom-to-be
Mrs. Virginia
Soule (middle)
and her
mother/coach,
Mrs. Gladys
Hilton.

A (URO)Dynamic Approach

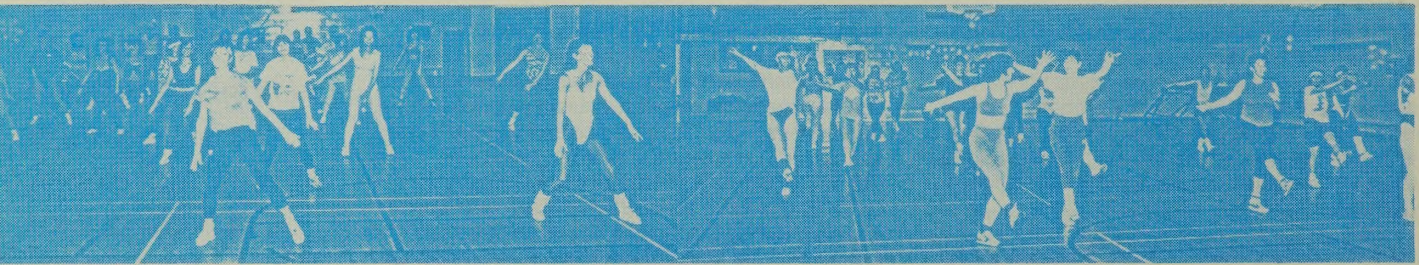
Picture an average 45-year-old mother of three. She's fit; she plays tennis twice a week or perhaps does aerobics at the Y. However, she has a problem. Frequently when playing tennis or even laughing or sneezing, she feels wet. 'Doctor,' she says to her family physician, only half joking, 'I'm wetting my pants.'

She is not alone. According to some statistics, 21 to 26 percent of women between the ages of 15 and 64 have some form of urinary incontinence--the inability to control the passage of urine. And it is not necessarily an older persons' disease, as many believe. In one study, 50 percent of nursing students reported some problems with incontinence.

It is also not amusing. Older women, in particular, become socially isolated for fear

equipment is used to accurately diagnose a patient's specific problem. A urethroscope, for example, can actually spot a fallen bladder, while other equipment can measure intra-abdominal and bladder pressures. As Dr. Kalbfleisch says, "Diagnosis can be very difficult. Bladder infections can mimic incontinence problems. Some medications may cause incontinence. Even a lack of estrogen can result in the inability to control urination. It is most important that all other possible causes be eliminated."

Stress incontinence is caused by a weakness in the pelvic floor. Patients with this diagnosis might benefit from estrogen therapy. Or a temporary measure might be a pessary ring in the vagina, which holds the bladder up and is useful for women who cannot be operated on



they might 'have an accident' away from home. They feel rejected by their friends and family. They can't stand the smell.

However, urinary incontinence need not be a social death sentence. Approximately 90 percent of cases of stress incontinence can be helped to some degree. Other forms of incontinence can be managed with medication. Says Dr. Rick Kalbfleisch, incontinence specialist in the Department of Obstetrics and Gynecology, "In most cases, something can be done. It isn't just a natural product of the aging process. You don't have to put up with it."

There are several different types of incontinence, some resulting from certain diseases or medications. The most common, however, are stress incontinence, where a small amount of urine is leaked during exercise, coughing or sneezing spells; and urge incontinence, an urgent desire to urinate, often with the result that the individual cannot get to the bathroom in time.

Dr. Kalbfleisch specializes in urodynamics, in which extremely sensitive, sophisticated

or who are still having children. Surgery, however, is the most effective measure, Dr. Kalbfleisch says. "People don't realize that there are some new surgical techniques that are particularly effective." For bladder repair, Dr. Kalbfleisch prefers the abdominal method (as opposed to the vaginal method) in which there is a stitch put on either side of the bladder which is then attached to the pubic ligament.

For urge incontinence, medication is indicated, although there may be some unpleasant side-effects such as dry mouth. But whatever the remedy, Dr. Kalbfleisch stresses, the problem will almost certainly be more manageable than it was. In his busy practice, he handles up to eight new referred patients a day and even with the help of a Clinical Scholar, there is a six-week wait. However it is important that people that people do bring their problems with urinary incontinence, first, to their family physicians, who then might refer them. As Dr. Kalbfleisch says, "You don't have to live in social isolation anymore."



Scoping

It's not often you see a technological development abandoned, then retrieved, and hailed as a vital diagnostic tool in the fight against cancer.

That, however, is what happened to the colposcope--a powerful backlit microscope on a stand that represents one of the best methods of diagnosing the causes of abnormal pap smears.

Developed in the early 1900s, it was thought too cumbersome to be of any value. However, medical researchers in the 1960s 'rediscovered' the colposcope and enlisted it in the fight against cervical cancer, which, unfortunately, had begun to grow by leaps and bounds. In those days, the pap test had become a regular part of most women's annual check-ups. But this served as a screening tool only. An abnormal pap smear merely offered an indication of a problem; it was not a diagnosis of cancer. Colposcopy took it from there.

Dr. Joan Murphy, a gynecologist with additional training in colposcopy and in laser surgery leans forward enthusiastically as she talks about the colposcope and the Colposcopy Clinic. She and five other gynecologists work in the clinic, directed by Dr. Paula Roth. It is the referral centre for the Region and the doctors see more than 3,000 patients a year. "We are," she says, "Consultants to consultants. And as well as the regular cases, we get the tricky ones."

As a result, there often is a long wait to get into the clinic--sometimes six to eight weeks. "However, we're dealing with a process that has taken years to develop to the point where a pap smear shows up as abnormal. And in most cases it will take years before it turns into something bad." Emergencies, she stresses, do not wait. "It's a triage system where the emergencies can be slotted in immediately and the cases that can wait, do."

Dr. Murphy snaps on a TV set in the tiny examining room. On the examining table is a young patient. Dr. Murphy chats easily with her, and she relaxes. "Now, we'll do another pap just to be sure we get the same results," she explains. "Then I'm going to wash your cervix with acetic acid (that's vinegar!) and it might feel a bit cool." The vinegar causes the abnormal cells to become whiter. The patient is watching, fascinated, on the TV screen as a

group of what looks to be pimples whiten. A green filter brings them into greater contrast. "We have only one video camera, and we need another," Dr. Murphy explains. "The patients feel they're participating when they can see what's happening on the screen. And that reassures them."

At this point, if she is able to see the whole area and make an adequate assessment, the doctor often knows what the abnormality is. ("Because of our experience we can make very good educated guesses.") A biopsy is also needed and through the colposcope, can be taken with minimum discomfort. If a lesion has been diagnosed previously, she can proceed with treatment; the laser is right there. Or she can book another appointment for laser surgery or freezing. More radical treatment such as a cone biopsy or a hysterectomy likely would be done by the patient's own gynecologist, if she has one, or by Dr. Murphy or one of her colleagues if she doesn't.

In any case there are no surprises. Each patient has been thoroughly briefed by Nurse Joan Randazzo, who takes the history, provides them with a brochure on colposcopy and answers all their questions.

One of the most frequently asked questions is: Have I got cancer? And, in the vast majority of cases the answer is no. Says Dr. Murphy: "A large number of abnormal smears aren't malignant. And those that are, we're seeing early. These can often be treated conservatively, whereas before, they frequently weren't spotted until surgery was required."

She does see large numbers of cases of wart virus or genital warts. These are co-carcinogens; Some do cause cancer, some don't. They also have a habit of spreading through sexual contact. And many types keep coming back. Dr. Murphy treats them, then tries to follow up. "Unfortunately, many people don't understand how serious these can be and become 'no shows'," Dr. Murphy says. Her colleague, Dr. Greg O'Connell, has designed a study on compliance which will also try to spot potential 'no shows' in an effort to reach them. "We're not judgmental," Dr. Murphy says. "We just want to make sure they stay healthy."

The patients
feel they're
participating.
It reassures
them.

Sexual Medicine

A recent newspaper article carried the following story: "About five years ago, after the birth of my son, I completely lost my desire for sex. I went to a psychologist, a gynecologist, an endocrinologist but nothing worked. This was an important part of my marriage and suddenly it was gone."

Of course this woman's story is not unusual; tabloids and magazines across North America eagerly seek out and print stories about sexual problems, along with 'expert' advice on how to 'cure' them.

But lost in this flurry of media hype are people—men and women whose lives are diminished because of sexual problems and who may not know where to turn.

Enter the Sexual Medicine Unit at Henderson Division. The unit, with its two therapists, recently moved to the Civic Hospitals from McMaster. It has been counselling people with sexual problems (and achieving a worldwide reputation) for more than 14 years.

Dr. John Lamont and Ms. Leslie Anderson provide confidential counselling on sexual problems to couples and singles. They see only patients who have been referred by GPs, specialists, social workers or other counsellors; on average they see four to six repeat patients and one new patient in their daily clinics. Because Henderson Division is a teaching hospital and the Sexual Medicine Unit was originally set up to train people in sexual counselling, interns and residents in obstetrics and gynecology, family medicine and psychiatry are involved in counselling sessions, a factor that Dr. Lamont suggests encourages critical thinking and a team approach to patients' problems. "There's no question the patient benefits from this approach," he says

The unit sees both men and women ("We prefer to see couples, if the person seeking counselling is involved in a relationship," says Ms. Anderson) with a variety of problems: common sexual dysfunctions,

such as the inability to have an orgasm or chronic pelvic pain in women; premature ejaculation and problems in getting and maintaining erections in men, and desire problems in both sexes. But in dealing with couples they look at the sexual aspects plus other aspects of the relationships: parenting, common interests, friends, and communication.

"Our role is a stimulus to get the couple to focus on improved communication," says Ms. Anderson. Dr. Lamont adds: "We are good listeners and can help clarify their problems. We also can provide them with information. But the couple has to be willing to work at improving the communication between them."

Dr. Lamont, who is a gynecologist, also is able to examine patients and assess any medical factors involved in their dysfunction. Ms. Anderson, who is a sex therapist with a nursing and psychiatric counselling background, has a particular interest in the dynamics of relationships.

They agree that their success rate is high. Particularly in areas of sexual dysfunction, such as orgasmic problems or vaginismus. "Of course, it depends on the problem," Ms. Anderson suggests. "It may simply be a case of lacking information and they'll only need two sessions. Or it may be a relationship issue, and they may be in counselling for over a year. Our measure for improvement is simple: Is anything happening? If it's not and the couple has been in counselling for awhile, perhaps they're not working at it."

Says Dr. Lamont: "We do get a good outcome. Sex and relationship therapy is all we do and the more often we do it the better we get." He, too, believes it depends on the problem: "When we get a man who is having erection problems and has been through some major personal trauma, we have to treat, not the erection problem, but the underlying depression. We help him understand; we help him grieve, we help him adjust. But we may not yet be able to help him have an erection."

In the past 10 years there has been an increase in the number of male patients coming to the clinic. Both counsellors believe this is because men now feel more comfortable talking about sexual problems. "Before they just used to live with it," comments Dr. Lamont. This could be due in part to the more relaxed approach society now takes to sex. Perhaps the media hype has brought something to the party, after all.

Dr. John Lamont (left), **Leslie Anderson** (centre), and **Chief Resident, Dr. Ruth Dyal**, compare notes before a consultation.



by Noel Robb

In the spring of 1987, the Hamilton Civic Hospitals Foundation (HCHF) went looking for more than 100,000 babies who came into this world via Mount Hamilton/Henderson General. A Baby Alumni Club was formed to be the nucleus of a special family of friends who would help the HCHF raise \$500,000 to renovate Henderson's half-century-old Maternity Wing. Our Baby Alumni family also will help us celebrate the 50th Anniversary of the wing through participation in a number of events this fall including a gala Alumni Homecoming.

A publicity campaign was launched to find these babies spearheaded by Henderson Stork, the Campaign Chairbird. It was an all-out search using direct mail, bus shelter and newspaper advertising; ads and articles in area newspapers; public service announcements, interviews and phone-in show appearances on Toronto and Hamilton radio stations plus letters to the editors of major Canadian newspapers. We were looking for Henderson Baby Alumni. And we found them.

From Summerside, P.E.I. to Richmond, B. C., thousands of Henderson babies started writing, not just to join the club but to tell us some wonderful stories of how they came to be Henderson babies. We would like to share one of these special letters with Touchstone readers.

Dear Henderson Stork,

I'm very proud to say that I'm one of the many premature babies that successfully 'graduated' from Mount Hamilton Hospital and went home a healthy daughter.

Our parents Roy and Marguerite Baker were totally unprepared back on February 10, 1951, when Mom delivered undiagnosed triplets. We probably wouldn't have survived without the skillful dedication of Dr. Overend and Dr. Green as we were only about 2 1/2 lbs. each. Baby #1 (Bonnie 2 lb. 8 oz.) is a healthy and successful mother of five, living in Ancaster, and a former maternity nurse. Baby #2 (Barbara 2 lb. 9 oz.) --that's me--is also a nurse who specialized in ill and premature baby care. I'm the mother of four children. Both Bonnie and I are totally healthy except that we wear glasses and have some hearing loss developed in our early childhood. Our brother (Allan 2 lb. 11 oz.) lived for two and a half years and died due to complications that seem connected to anoxia and severe respiratory distress after delivery. Dr. Overend took photos of all three of us lying in those old box-type heaters with big enamel funnels at our faces. We have spent hours over the years marvelling at those pictures.

We came home at 5 1/2 lbs. and even at that, Mom says we were unable to suck from a nipple. Times were difficult with so many babies at one time and

Friends of the Civics

no money and our parents did without for many years.

The times may have changed and all the equipment and techniques too, but all the dedicated doctors and nurses worked a miracle for us and I can honestly say that our parents have always been and still are very proud of us and we are glad to be alive.

Please keep on caring and continue to fight for all those preemies, and for all babies.

Sincerely,

Barbara Jane Baker Jardine
Brookdale, Man.



As Mrs. Jardine says, the times may have changed but the quality of care and concern of the staff for Henderson's babies and new mothers has not. Our desire now is to bring our outdated facilities more into line with that caring and concern.

More than 4,500 Henderson babies have joined the Baby Alumni club, and more than \$200,000 has been raised so far to help improve conditions in Maternity. These improvements such as central air conditioning, new equipment and more comfortable, homelike surroundings support our philosophy of family-centred care and add to our ability to provide that special care Mrs. Jardine mentions.

Plans are currently under way for the Baby Alumni reunion this fall to coincide with Maternity's 50th Anniversary Celebrations. For more information on the Henderson Baby Alumni Club, contact the Hamilton Civic Hospitals Foundation, 237 Barton Street East, Hamilton, Ontario L8L 2X2

Roy and Marguerite Baker's triplets: Allan, Bonnie and Barbara and their Mt. Hamilton nurses: Dorothy Leland (left), Elizabeth Justason and Betty Stanton.

Facts & Figures

Hamilton Civic Hospitals
1987/88
ANNUAL REPORT

	HAMILTON GENERAL	HENDERSON GENERAL	CONSOLIDATED
PERSONNEL			
Paid Hours	2,664,047	2,703,566	5,367,613

EMPLOYEES

- Full Time Equivalent			
Nursing	748	730	1,478
Other	618	657	1,275
TOTALS	1,366	1,387	2,753

SET UP BEDS

Private	31	63	94
Semi-Private	40	178	218
Standard	344	373	717
Bassinets	-	108	108

MEDICAL SERVICES

Autopsies	742	148	890
Emergency Visits	39,814	39,785	79,599
Laboratory Units	9,402,082	9,953,421	19,355,503
Occupational Therapy			
Attendances	7,880	11,180	19,060
Out Patient Visits	86,675	68,837	155,512

	HAMILTON GENERAL	HENDERSON GENERAL	CONSOLIDATED
Physiotherapy Attendances	35,322	44,934	80,256
Speech Therapy Attendances	1,396	17	1,413
Nuclear Medicine Units	382,259	403,992	786,251
Medical Diagnostic Units	2,123,245	858,153	2,981,398
Surgical Operations	9,075	10,009	19,084
X-Ray Exams	77,023	69,670	146,693
Nutritional Counselling Visits	3,287	970	4,257

OTHER SERVICES

Laundry Poundage (kg)	1,171,187	1,334,143	2,505,330
Meals Served	652,548	859,326	1,511,874
Steam Produced (kg)	33,109,267	40,146,291	73,255,558

PATIENTS - ACTIVE

Admissions	9,524	15,733	25,257
Separations	9,561	15,787	25,348
Births - Live	-	1,967	1,967
Patient Days	133,189	152,069	285,258
Average Days of Stay	13.9	11.6	11.5
Occupancy Percentage	87.9	83.1	85.3

CASES TREATED (CALENDAR YEAR 1987)

	HAMILTON GENERAL		HENDERSON GENERAL		CONSOLIDATED	
	Patients	Days	Patients	Days	Patients	Days
Cardiology and Cardiovascular	2,400	25,317	-	-	2,400	25,317
Dental	76	172	64	187	140	359
General Surgery	1,171	12,525	2,486	22,522	3,657	35,047
Gynecology	-	-	2,620	15,530	2,620	15,530
Medicine	1,651	31,094	4,818	71,095	6,469	102,189
Neurology and Neurosurgery	982	17,477	-	-	982	17,477
Newborn	-	-	1,921	10,059	1,921	10,059
Obstetrics - Not Delivered	-	-	501	1,381	501	1,381
Obstetrics - Delivered	-	-	1,976	10,755	1,976	10,755
Ophthalmology	217	342	-	-	217	342
Orthopedic	1,029	12,742	1,063	15,345	2,092	28,087
Otolaryngology	436	717	288	865	724	1,582
Pediatrics	-	-	52	778	52	778
Plastic Surgery	407	2,939	102	418	509	3,357
Psychiatry	112	4,082	201	6,362	313	10,444
Thoracic Surgery	61	572	-	-	61	572
Traumatology	325	12,673	-	-	325	12,673
Urology	642	5,617	825	5,085	1,467	10,702
TOTALS	9,509	126,269	16,917	160,382	26,426	286,651

Highlights 1987/88



**Hamilton
General
Division--
Before and After**

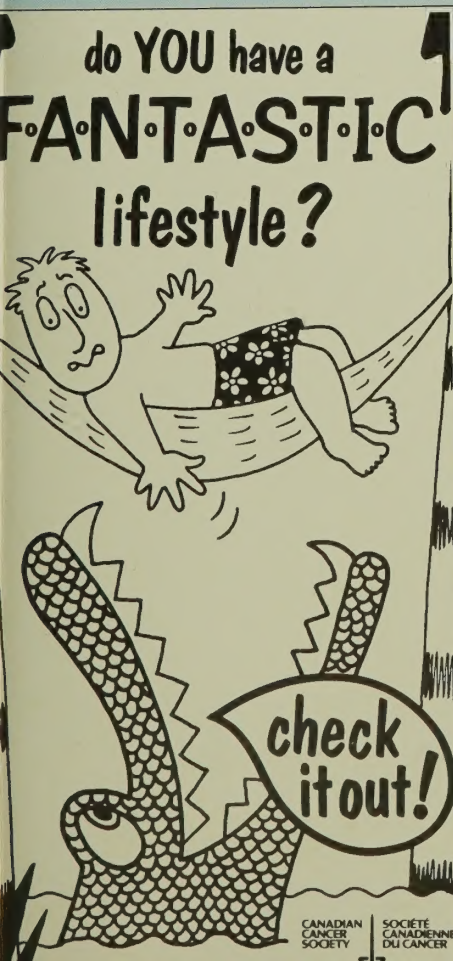


**The ribbon is cut
on the renovated
Labor & Delivery
Ward!**



**Three cheers for our junior
volunteers, seen here on
Junior Awards' night held at
Henderson Division in May,
1987.**

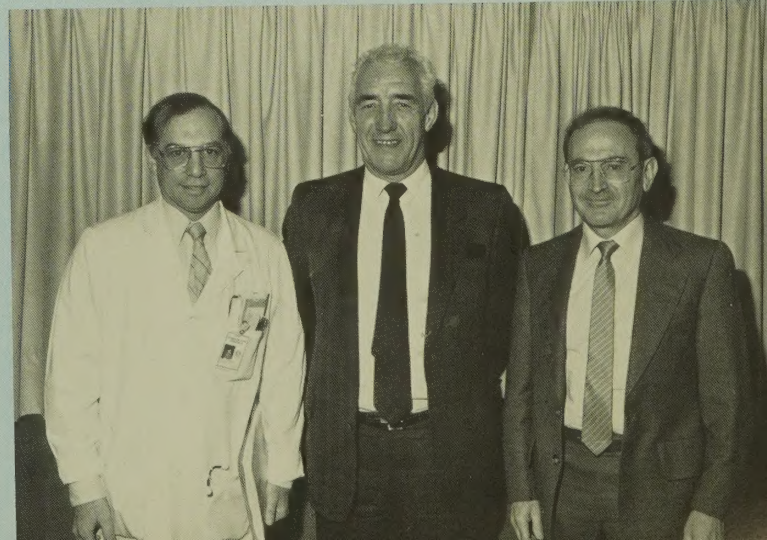
**The 'Fantastic Lifestyle' theme
kicked off Health Promotion
Week at Henderson Division.
The January launch served to
introduce a new Health
Promotion program for
employees.**



**Dr. Anthony Carr (left),
Director of the Southam
Day Centre, and Chief
Operating Officer of the
General Division, Dr.
George Woodward, cut
the ribbon to launch the
Day Centre pilot program.**



**The people behind the
announcement of the
Hamilton Civic Hospital's
new research initiative: Dr.
George Browman (left),
interim Director of the
Research Centre to be
located initially at
Henderson division, Dr.
Jack Hirsh (right), Director
of Research effective
September 1988 and Prof.
Michael Gent (middle),
Head of the Clinical Trials
Methodology Group which
moves this month to
Henderson.**





Henderson Division

Over the past year, the research and education aspects of our mission as a teaching hospital have been in the forefront.

One of the year's highlights was the announcement that the Hamilton Civic Hospitals Research Centre would be established and located initially at the Henderson site. Two research groups currently based at McMaster University Medical Centre will move to the Henderson and a third group will be developed; The research focuses on thrombosis and Atherosclerosis, Clinical Trials Methodology as well as Pharmacology of Hyperlipidemias and Vascular Diseases. There is no question that this increased commitment to research will enhance the hospital's academic activities and patient service delivery.

Also in the past year, a patient education committee and a staff education committee were established. These multidisciplinary groups are planning programs which will enable our closed-circuit television system to be better utilized as an educational tool.

As well, individual departments are continually organizing and participating in academic activities, reflecting the on-going commitment to the learning process which is required to keep on top of the latest health care developments. For example, nursing staff was involved in organizing the fourth National Conference in Oncology Nursing: "New Horizons", as well as the Critical Care '87 Conference. And the clinical student program in respiratory therapy has been operating at full capacity; we are proud to have the Henderson Division identified as a superior clinical training site for students in this program.

Another new education initiative at the Henderson was the start up of the Health Promotion program - which began with Health Promotion week in January 1988. The program concentrates on employee health and tackles those health issues identified in a staff survey as being most crucial, including mental well-being, nutrition & physical activity and smoking cessation.

Last year also saw the completion of the Master Program and the first draft of the Master Plan. More than a year in the making, with the participation of every department, these two documents map out the Henderson's future in terms of medical programs and support services, plus the facilities required to house them.

We are already meeting the future head-on through the rapid expansion of computerization in the hospital. Last year, the anatomical pathology laboratory was computerized; the pharmacy and materials management systems were expanded and others are in the planning stages.

The grand opening of the newly renovated labor and delivery unit took place in June 1987. This was the culmination of a great deal of time and effort spent planning all the concepts and details. Our efforts were well rewarded, though, because the result has

placed the Henderson at the leading edge of maternity care. The Hamilton Civic Hospitals Foundation helped fund the renovations and the Volunteer Association's generous donation allowed the Henderson to purchase two additional birthing beds so that we could outfit the new unit with the latest equipment.

Other renovations included the massive window replacement project in the 70 Wing. This began in August 1987 and will continue through to September of this year. Phase 2 of the fire alarm system upgrade has been started and renovations have taken place in the radiology department, ambulance dispatch and central supply room.

None of the accomplishments of the past year would have been possible without the dedication of our staff and volunteers. Their adaptability and professionalism in the face of displaced wards and implementation of new systems have been admirable.

Finally, I would like to pay special tribute to Mrs. Lynda Hinkley who gave 23 years of service to the Henderson and who passed away in January of this year. The former Supervisor of Medical Records at the Henderson until September 1987, Mrs. Hinkley had just begun a new position at the General Division prior to her death. We were all saddened by her death and will not forget her helpfulness and quiet presence.

*Mr. P.C. Johnson
Vice-President, Hamilton Civic Hospitals
Chief Operating Officer, Henderson Division*

Medical Staff Advisory Committee

"...And we must take the current when it serves, or lose our ventures."

Julius Caesar. (Act IV, Sc III)

Last year, I referred to developments at the Hamilton Civic Hospitals and some of the interesting projects which had been started. This year, I shall describe their progress.

The formation of the new Hamilton Civic Hospitals Research Centre, to be located at Henderson Division, was announced on December 15, 1987. The administrative structure for research in the Civic Hospitals was established with the creation of the new position of Research Director; a Research Committee of the Board of Directors; and the renaming of the Research Committee of the Medical Staff Advisory Committee to the Institutional Review Board, a term which is in keeping with international terminology. Dr. Jack Hirsh becomes the first Research Director.

It is also worthy of note that, in this year, the Institutional Review Board under Chairman Dr. M.J. McQueen approved 44 research projects from six

hospital departments and the Cancer Centre. These projects involved approximately 40 medical, special professional and scientific staff and encompassed such diverse fields as cancer, heart disease, infectious disease, thromboembolic disease, breast screening and depression.

The increasing complexity of medical care has been evidenced by the creation of a new Department of Critical Care (Chief, Dr. J.R. Hewson); a Stroke Unit (Director, Dr. R. Duke), and a Utilization Committee (Chairman, Dr. R. Bloch) as well as a psychiatric day hospital (under Dr. A.C. Carr); a Human Immunodeficiency Virus Committee (Chairman, Dr. O. Wesley-James) and a committee to study the present and future use of lasers in medicine (Chairman, Dr. H.O. Stolberg). Medical Directors of the Short-Stay Units were appointed: Drs. M.B. Greenspan and B. Lumb at the General Division and Drs. I. Davis and P. Roth at Henderson Division. As well Dr. W. E. Pine was appointed Head, Service of Anesthesia at the Henderson Division and Dr. T. Ryan, Head of the Service of Internal Medicine at the General Division. Dr. H. Stolberg retired after 23 years as Chief of the Department of Diagnostic Radiology at the Hamilton General Division, to be replaced by Dr. M. Romeo.

University/Hospital relationships were strengthened as a committee chaired by Dr. T. Seaton studied then confirmed the importance of linking Faculty of Health Science appointments with active hospital staff appointments.

On the administrative front, the Appeal which the hospital made to the Ministry of Health for supplemental funding has been acknowledged by the Ministry to be legitimate. All that remains is for the Administration and the Ministry to work out the details of cash flow. This should begin early in the next fiscal year (1988-89), after which we should begin to see improvement in underfunded patient services.

Once again, the Hamilton Civic Hospitals received a commendable accreditation report, receiving a two-year Accreditation. Among those examples singled out for special commendation were: the quality assurance program; the Medical Staff By-Laws and illustrations of collaboration between medical and nursing staffs and other hospital departments.

It is clear, in reviewing the year's activities, that not only are the important initiatives begun last year continuing and coming to fruition, but that new ones have been started.

Finally, it is a pleasure to acknowledge the hard work of the many members of the medical staff, the Advisory Committee and its Executive for their dedication and advice in conducting the affairs and policies of the Hamilton Civic Hospitals, which are so important in ensuring adequate care of our patients.

*Dr. I.O. Stewart, F.R.C.P. (C),
Chairman, Medical Staff Advisory Committee
Hamilton Civic Hospitals*

Hamilton Civic Hospitals Volunteer Association

No one could be president of the Hamilton Civic Hospitals Volunteer Association and accountable for the daily details of the organization without being impressed with two major factors...

The first is the tremendous number of details needed to run an organization of this size.

The second is the equally tremendous amount of time given freely by volunteers.

There's no doubt our organization is large. For instance, the volume of sales (not profits!) of our three gift shops and two snack bars totals almost a million dollars. And one can imagine the kind of detail that goes into an enterprise of that size: from the purchase of goods to be sold, to the scheduling of employees, to the development of policies affecting these. Not to mention the marketing decisions that affect our profits--profits that are critical during the current climate of economic restraint.

Our hospitals have learned to depend on volunteers to supply some of the capital needed to purchase new technology and to fund the staff education needed in a great teaching hospital such as ours. And the volunteers are proud to accept their responsibilities as part of this healing community.

New volunteer services added to existing ones include the provision of Spanish interpreters at the North Hamilton Community Health Centre and visits to geriatric patients in the Terrace and to amputee ward patients.

Who does one thank for all these 'gifts of self'? Really, the whole organization--the board, the volunteers, and particularly the two Directors of Volunteers who tend the morale of the volunteers so well. It takes everyone to respond to a need of this magnitude.

And finally our sincere appreciation goes to Dr. Noonan, Dr. Woodward, Mr. Johnson and their staffs for the support and advice that is always there.

*Miss Mary Gibbon,
President
Hamilton Civic Hospitals Volunteer Association*

Financial Statements

Balance Sheet

as at March 31, 1988 and 1987

Assets

	1988	1987
Cash and Investments	\$10,603,149	\$5,173,120
Grants and Accounts Receivable	9,544,822	9,794,714
Inventories	3,359,867	2,883,424
Prepaid Expenses	822,626	340,230
Total current assets	24,330,464	18,191,488
Due from Other Funds - non-current	-	574,522
Fixed Assets - Equipment	42,663,497	31,046,608
Less Accumulated Depreciation	23,983,834	20,951,720
	18,679,663	10,094,888
Total Operating Fund Assets	43,010,127	28,860,898

Redevelopment Fund (note 2)

Cash and Term Deposits . .	9,657,477	7,028,357
Accounts Receivable - Construction Grant	17,289,210	3,623,053
Due From Operating Fund . .	2,252,999	-
Construction in Progress. . .	59,267,328	41,835,919

Total Redevelopment Fund Assets	88,467,014	52,487,329
---	------------	------------

Total Assets	\$131,477,141	\$81,348,227
------------------------	---------------	--------------

Liabilities and Fund Balances

Operating Fund

	1988	1987
Accounts Payable and Accrued Liabilities	\$16,152,140	\$11,071,160
Due to Redevelopment Fund	2,252,999	-
Total Current Liabilities . . .	18,405,139	11,071,160
Operating Fund Balance (note 3)	24,604,988	17,789,738

Total Liabilities and Operating Fund Balance	43,010,127	28,860,898
--	------------	------------

Bank Loan	20,701,365	5,153,915
Accounts Payable	3,187,694	1,731,879
Holdbacks Payable	5,310,627	3,765,616
Redevelopment Fund Balance	59,267,328	41,835,919

Total Liabilities and Redevelopment Fund Balance	88,467,014	52,487,329
--	------------	------------

Total Liabilities and Fund Balances	\$131,477,141	\$81,348,227
---	---------------	--------------

Notes to Financial Statements - see page 24

1987/88

Statement of Changes in Financial Position

for the years ended March 31, 1988 and 1987

Sources of Working Capital	1988	1987
Surplus for the year	\$1,612,318	\$1,275,879
Charges to operations not requiring an outlay of working funds - Depreciation	3,275,108	2,191,800
Donations received for Capital Expenditure	265,762	324,310
Decrease in Due from Other Funds - non-current	574,522	509,214
Transfer from Redevelopment Fund	5,425,665	-
Total Working Capital Provided	11,153,375	4,301,203
Application of Working Capital		
Purchases of equipment - net	3,638,234	2,769,813
Transfer of Depreciable Equipment from Redevelopment Fund	8,221,649	-
Expenditure to buildings owned by the City of Hamilton	488,495	204,043
Total Application of Working Capital	12,348,378	2,973,856
(Decrease) Increase in Working Capital	(1,195,003)	1,327,347
Working Capital Beginning of Year	7,120,328	5,792,981
Working Capital End of Year	\$5,925,325	\$7,120,328

Statement of Revenue and Expense and Operating Fund Balance

for the years ended March 31, 1988 and 1987

Revenue	1988	1987
Ministry of Health Funding		
- Hospital Services	\$127,740,118	\$115,611,899
- Subsidiary Service	2,145,286	1,869,995
Patient Services Revenue . .	10,721,877	9,480,142
Other Income	4,231,855	3,023,501
Total Revenue	144,839,136	129,985,537
Expense		
Care of Patients	95,845,715	86,272,889
Patient Support Services . .	19,578,014	17,989,814
General Services	21,673,801	20,199,152
Depreciation	3,275,108	2,191,800
Other Expense	708,894	186,008
Subsidiary Expense	2,145,286	1,869,995
Total Expense	143,226,818	128,709,658
Surplus for Year	1,612,318	1,275,879
Operating Fund Beginning of Year	17,789,738	16,393,592
Add		
- Donations	265,762	324,310
- Transfer from Redevelopment Fund	5,425,665	-
	25,093,483	17,993,781
Less		
- Expenditures to buildings owned by the City of Hamilton	488,495	204,043
Operating Fund End of Year	\$24,604,988	\$17,789,738

Auditors' Report

We have examined the balance sheet of the Hamilton Civic Hospitals as at March 31, 1988 and the statements of revenue and expense and operating fund balance, and changes in financial position for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position of the hospitals as at March 31, 1988 and the results of their operations and the changes in their financial position for the year then ended in accordance with the accounting principles set out in the notes to the financial statements applied on a basis consistent with that of the preceding year.

Hamilton, Ontario

June 8, 1988

Pannell Kerr MacGillivray, Chartered Accountants

Notes to Financial Statements

Note 1 - Significant Accounting Policies:

- a) The financial statements have been prepared using the accrual method of accounting, revenue is recorded when earned and expenses are recorded when incurred. The financial statements do not include the assets, liabilities, and activities of any organizations such as the Volunteer Association and the Foundation which, although related to the Hospitals, are not operated by it.
- b) Inventories are carried at the lower of cost and replacement value. The moving average cost method is used to value stores inventory. The first in, first out cost method is used to value pharmacy and other departments' inventories.
- c) Fixed assets are recorded at cost and depreciated on a straight-line basis over their estimated useful lives from 5 to 20 years.
- d) Under the sick leave benefit plan for employees, unused sick leave accumulates and may be used for sick time in future years. In addition, employees with five years or more service are entitled to cash payments on a portion of their sick bank upon termination of employment. It is the policy of the Hospitals not to recognize the amount of the liability of the sick bank in the financial statements, but to consider any payments from the accumulated sick bank as an expense in the year of payment. The termination sick bank payments were \$616,150 for 1987/88 and \$575,801 for 1986/87.
- e) Donations are accounted for as increases in the operating fund balance.
- f) Capital grants, except for the Hamilton General Hospital Redevelopment, are applied against expenditures incurred for additions and improvements to buildings which are owned by the City of Hamilton.

Note 2 - Hamilton General Hospital Redevelopment

The total project cost is expected to be \$84,400,000, including \$16,100,000 of depreciable new equipment. At March 31, 1988, \$8,221,649 of new equipment was put into use and transferred to the Operating Fund. Construction will be partially funded by a special construction grant from the Ministry of Health in the amount of \$60,730,000. The balance of the required funding will be provided by the Hospitals and the Hamilton Civic Hospitals Foundation. Construction costs are being financed by a bridge loan. The Ministry of Health is committed to provide grant funds to repay this loan over a ten-year period. All interest incurred on this loan is to be paid by the Ministry of Health.

The redevelopment project is expected to be completed in 1989. Upon completion, the buildings will be contributed to the City of Hamilton.

Note 3 - Statutory Provision

The operating fund balance is vested in the Hospitals in trust for the Regional Municipality of Hamilton-Wentworth and/or the City of Hamilton. The use of the operating fund balance is restricted by the Hamilton Civic Hospitals Act, 1978.

Note 4 - Lease Obligations

The Hospital is committed to operating lease payments of \$828,000 annually for 1988/89, \$674,000 in 1989/90, \$545,000 in 1990/91, \$447,000 in 1991/92 and \$88,000 in 1992/93.

Note 5 - Vacation Pay

It is the policy of the Hospitals to recognize the liability for part-time nursing staff vacation pay. This liability amounted to \$904,000 for 1987/88 and \$785,000 for 1986/87. Vacation pay for full-time staff is recorded as an expense in the year paid.

Note 6 - Pension Plan

Substantially all of the employees of the hospital are eligible to be members of the Hospitals of Ontario Pension Plan which is a multi-employer defined benefit, final average pay contributory pension plan. Employer contributions made to the Plan during the year by the hospital amounted to \$1,529,000 (1987 - \$1,933,000). These amounts are included in employee benefits expense in the operating fund statement of revenue and expense and operating fund balance.

The most recent actuarial valuation of the plan as at December 31, 1986 indicates the plan is fully funded.

Employer contributions to the Hospitals of Ontario Pension plan have been waived for 1988. The Ministry of Health funding has been reduced by an equal amount. This amounted to \$601,900 for the three months ending March 31, 1988.

Note 7 - Public Liability Insurance

In recent years there have been substantial increases in the premiums charged by the insurance industry for public liability insurance. As a result, on July 1, 1987 Hamilton Civic Hospitals joined a group of Hospitals to form the Hospital Insurance Reciprocal of Ontario (HIRO).

HIRO is a pooling of the public liability insurance risks of its members. All members of the pool are subject to assessment for losses experienced by the pool for the years in which they were members, on a pro rata basis, based on the total of their respective deposit premiums. To March 31, 1988 no assessments have been made. The hospital has expensed \$700,000 of deposit premium as an administrative expense for the year ended March 31, 1988.

Note 8 - Patient Accounts Receivable

Included in Patient Accounts Receivable is \$2,491,241 resulting from expenses in excess of approved Ministry of Health funding. Collection of this amount is dependant upon approval of the Ministry of Health.

Medical Staff Advisory Committee

Chairman - Dr. I.O. Stewart

Vice-Chairman - Dr. T.L. Seaton

DEPARTMENT OF ANESTHESIA

Chief - Dr. E.J. Ashworth

*Head of Service, Henderson
- Dr. W.E. Pine*

*Head of Service, Hamilton General
- Dr. R. A. Browne*

DEPARTMENT OF CRITICAL CARE

Head - Dr. J. R. Hewson

DEPARTMENT OF DIAGNOSTIC RADIOLOGY

Chief - Hamilton General - Dr. M. Romeo

Chief - Henderson - Dr. J.G. Thomson

DEPARTMENT OF EMERGENCY CARE

Chief - Dr. K.A. Ockenden

DEPARTMENT OF EYE MEDICINE & SURGERY

Chief - Dr. H.C. Witelson

DEPARTMENT OF GENERAL PRACTICE

Chief - Dr. J.J. Homer

Member-at-Large - Dr. L. Jurkowski

DEPARTMENT OF LABORATORY MEDICINE

Chief, Hamilton General - Dr. I.O. Stewart

Chief, Henderson - Dr. J.H. Thornley

DEPARTMENT OF MEDICINE

Chief - Dr. R.W. Cornett

*Deputy Chief, Henderson
- Dr. D. E. Dwyer*

*Deputy Chief, General
- Dr. A.G.G. Turpie*

*Service of Cardiology - Head
- Dr. D.A. Holder*

*Service of Clinical Hematology - Head
- Dr. G.P. Browman*

*Service of Dermatology
Head - Dr. P.J. Jenkin*

Service of Endocrinology/Metabolism

Head - Dr. A.R. McNabb

Service of Gastroenterology

Head - Dr. T.L. Seaton

Service of General Internal Medicine

Head - Dr. D.E. Dwyer

Service of Infectious Diseases

Head - Dr. L. Mandell

Service of Neurology

Head - Dr. R.J. Duke

Service of Nuclear Medicine

Head - Dr. C.N. Best

Service of Rehabilitation Medicine -

Head - Dr. R. Bloch

Service of Respiriology

Head - Dr. R.W. Cornett

DEPARTMENT OF OBSTETRICS & GYNECOLOGY

Chief - Dr. K.G. Lamont

Deputy Chief, Obstetrics - Dr. W.G. Green

*Deputy Chief, Gynecology
- Dr. D.C. Robinson*

DEPARTMENT OF PEDIATRICS

Chief - Dr. A.G. Hart

DEPARTMENT OF PSYCHIATRY

Chief - Dr. A.C. Carr

DEPARTMENT OF SURGERY

Chief - Dr. O.J. Mirehouse

*Deputy Chief, Hamilton General
- Dr. W.P. Finn*

Deputy Chief, Henderson - Dr. E.G. Isbister

Service of General Surgery

Head, General

- Dr. W.P. Finn

Head, Henderson

- Dr. Z. Kiss

*Service of Neurosurgery - Head
- Dr. S.W. Schatz*

*Service of Orthopedics and Fractures - Head -
Dr. I.W. Blackstone*

Service of Otolaryngology

Head - Dr. J.R. Cranston

Service of Plastic Surgery

Head - Dr. O.J. Mirehouse

Service of Thoracic & Cardiovascular Surgery

Head - Dr. J. Gunstensen

Service of Urology

Head - Dr. E.G. Isbister

Cancer Clinic

Director - Dr. W.M. Hryniuk

Dental Staff

Head - Dr. E.M.G. Dore

McMaster University, Faculty of Health Sciences Representatives

*Dr. G.H. Flight,
Associate Dean, Health Services*

*Dr. S. MacLeod,
Dean, Faculty of Health Sciences*

Medical Staff - Elected Representatives

President - Dr. S. Koziak

Vice-President - Dr. N. Gagic

Secretary - Dr. A.A. Hornich

Administration

*President and Chief Executive Officer,
Hamilton Civic Hospitals
- Dr. W.E. Noonan*

*Vice-President, Medical Affairs
- Dr. J.M. Phin*

*Vice-President, Hamilton Civic Hospitals and
Chief Operating Officer, Hamilton General
Division*

- Dr. E.G. Woodward

*Vice President, Hamilton Civic Hospitals and
Chief Operating Officer, Henderson General
Division*

- Mr. P.C. Johnson

*Nursing, Hamilton General
- Miss M. Charters*

Nursing, Henderson - Mrs. P. Mandy

Board of Directors

Mr. C. Waxman

RETURN POSTAGE GUARANTEED

Hamilton Civic Hospitals
237 Barton Street East
Hamilton, Ontario
L8L 2X2

HAMILTON PUBLIC LIBRARY



3 2022 21335622 9

Bulk	En nombre
third	troisième
class	classe

1818

Hamilton, Ontario

JUDITH MCANANAMA
CHIEF EXEC. OFFICER
HAMILTON PUBLIC LIBRARY
55 YORK BLVD.
HAMILTON ON
L8R 3K1

3150

Cover Photography

Art Director

Peter L. Hill

Photographer

Michael Dismatsek

Produced by

Public Relations Department

Hamilton Civic Hospitals

237 Barton Street East

Hamilton, Ontario, Canada

L8L 2X2

(416) 527-0271 Ext.: 4384